Standards for Health Services in Jails

2014

National Commission on Correctional Health Care

J-A-10
important

PROCEDURE IN THE EVENT OF AN INMATE DEATH

Standard

All deaths are reviewed to determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

Compliance Indicators

1. All deaths are reviewed within 30 days.
2. A death review consists of:
   a. An *administrative review*
   b. A *clinical mortality review*
   c. A *psychological autopsy* if death is by suicide
3. Treating staff are informed of the clinical mortality review and administrative review findings.
4. All aspects of the standard are addressed by written policy and defined procedures.

Definitions

An *administrative review* is an assessment of correctional and emergency response actions surrounding an inmate's death. Its purpose is to identify areas where facility operations, policies, and procedures can be improved.

A *clinical mortality review* is an assessment of the clinical care provided and the circumstances leading up to a death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved.

Psychological autopsy, sometimes referred to as a psychological reconstruction or postmortem, is a written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the individual's death. It is usually conducted by a psychologist or other qualified mental health professional.

Discussion

The intent of the standard is that preventable deaths are avoided.

A clinical mortality review is conducted to determine the appropriateness of the clinical care provided and the effectiveness of the facility's policies and procedures relevant to the circumstances surrounding the death. Generally, a clinical mortality review asks at least three key questions: Could the medical response at the time of death be improved? Was an earlier intervention possible? Independent of the cause of death, is there any way to improve patient care?

The clinical mortality review may be conducted by a unit physician not involved in the patient's treatment, a central office or corporate physician, or an outside medical group. Results of the review are to be communicated to the unit health staff involved.

The clinical mortality review includes a review of the incident and facility procedures used; training received by involved staff; pertinent medical and mental health services or reports involving the inmate; and recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures. For expected deaths, a modified review process that focuses on the relevant clinical aspects of the death and preceding treatment may be followed.

Corrective actions identified through the mortality review process are implemented and monitored through the facility's CQI program for systemic issues, and through the patient safety program for staff-related issues. Refer to A-06 Continuous Quality Improvement Program and B-02 Patient Safety for additional information and guidance.

A medical autopsy can often be helpful to health staff and should be requested for this purpose. When a medical autopsy is completed after the clinical mortality review is completed, the clinical review is appended with information from the autopsy report.

Included in the death review are those deaths, whether natural or otherwise, that occur off site while the facility is responsible for the inmate.